Strategy Research Project

REINTEGRATION OF NATIONAL GUARD SOLDIERS WITH POST-TRAUMATIC STRESS DISORDER

BY

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USAWC STRATEGY RESEARCH PROJECT

REINTEGRATION OF NATIONAL GUARD SOLDIERS WITH POST-TRAUMATIC STRESS DISORDER

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ABSTRACT

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Returning warriors from the streets of Iraq or the hillsides of Afghanistan to Main Street USA undergo a profound transition. Many experience considerable difficulty in returning to a civilian lifestyle. Since the Vietnam War, many returning veterans have been diagnosed with the invisible wounds of Post-Traumatic Stress Disorder (PTSD). An alarming number of soldiers returning from our current wars in Iraq and Afghanistan are likewise coming home suffering from PTSD. Guard soldiers are particularly vulnerable. Guard leaders must do all they can to strengthen the care of those who have been psychologically injured. They should implement preventive measures to provide Guard soldiers with sufficient resilience to counter combat trauma. To retain the force, we must better care for the welfare of our traditional citizen-soldiers and their families. Guard leaders need to discontinue the rapid out-processing and extend the decompression time to enable Guard soldiers to effectively reintegrate back into their civilian world. This SRP addresses the issues of returning Guard soldiers suffering from the invisible wounds of PTSD. It recommends procedures and policy that will provide better support for returning Guard veterans.

REINTEGRATION OF NATIONAL GUARD SOLDIERS WITH POST-TRAUMATIC STRESS DISORDER

> The great thing that I did not understand was why, when the active-component forces came back, the goal was to give them 10 days of reintegration training, yet when we brought back National Guard soldiers, the goal was to get them demobilized and back to their communities as soon as we possibly could without any of that same care.
>
> —Gen. Peter Chiarelli, Army Vice Chief of Staff
> Comments to NGAUS General Conference
> Nashville, TN Sept 2009

Returning warriors from the streets of Iraq or the hillsides of Afghanistan to Main Street USA undergo a profound transition. Many experience considerable difficulty in returning to a civilian lifestyle. The National Guard soldier's transition time is extremely limited. Unlike Active Component soldiers, Guard soldiers return home from combat almost directly; they must transition to civilian life in a matter of days. U.S. soldiers have traditionally faced significant readjustments when returning from war. Since the Vietnam War, many returning veterans have been diagnosed with the invisible wounds of Post-Traumatic Stress Disorder (PTSD). These veterans' coping skills have become drastically impaired. Guard soldiers are particularly vulnerable: They do not return to an Army base under the watchful eye of their platoon sergeant. They may not even retain close contact with fellow Guard soldiers with whom they deployed. Guard soldiers suffering from PTSD are essentially left alone to deal with their readjustment issues, perhaps in the hands of uncomprehending spouse or family. This SRP addresses the issues of returning Guard soldiers suffering from the invisible wounds of PTSD. It recommends procedures and policy that will provide better support for returning Guard veterans.

No matter whether our nation is in a “war of choice in Iraq” or a “war of necessity in Afghanistan”, we are a nation at war. It is the men and women of our Armed Forces who bear the greatest burdens of war. They deploy from homes and family. They endure the rigors and hardship of combat. They suffer physical and mental wounds.[1] Some of them make the ultimate sacrifice. Early evidence suggests that the psychological toll of these deployments – many involving prolonged exposure to combat-related stress over multiple rotations – is disproportionately high when compared to the physical injuries.[2] This is particularly true regarding PTSD, which cannot be stitched up. PTSD earns no Purple Heart, but for many it can fester over a troubled lifetime.[3]

Post Traumatic Stress Disorder (PTSD)

An alarming number of soldiers returning from war zones in Iraq and Afghanistan are coming home with a wound that did not bleed.[4] One in five Iraq and Afghan veterans suffer from PTSD or major depression.[5] Unlike the physical wounds that maim or disfigure, the wounds of PTSD often remain invisible to other service members, family members, and to society in general.[6]

Realities of combat expose soldiers to traumatic, life-threatening events – some of which involve killing other human beings. Even more traumatic, soldiers witness their comrades being killed or maimed – or the lives of innocent women and children wasted in the mayhem of combat. A recent Rand study has shown that soldiers who have been wounded or who vicariously experience traumas (such as – having a friend who was seriously wounded or killed) are more likely than others to have PTSD.[7]

As part of the warrior’s journey, many soldiers go through a dark and challenging time after encountering life-threatening, traumatic wartime experiences. These Soldiers

then experience either Post-Adversity Growth or Post-Traumatic Stress.[8] If the latter condition is left untreated, it can turn into Post-Traumatic Stress Disorder.[9] But uniformed observers may not be aware of the invisible wounds that result from life-threatening war-zone experiences. But this much we can comprehend: An increasing number of soldiers are returning from Iraq and Afghanistan with PTSD.

According to a Rand survey of veterans who have returned from Afghanistan or Iraq, an estimated 300,000+ veterans or 18.5 percent of those deployed since 2001 now have PTSD or major depression.[10] The Rand study also estimated that of the 1.64 million individuals who had deployed to Iraq as of October 2007, 14% are currently affected by PTSD.[11] Consequently, only about half of those affected veterans seek treatment.[12]

Acknowledge Psychological Injuries

Even when soldiers receive the best training, equipment, and leadership, prolonged fighting will inevitably cause psychiatric casualties.[13] During World War II, 15-25% of the total non-fatal battle casualties were neuropsychiatric.[14] The very fact that our military services acknowledged that men could be broken by battle and evacuated them may have been a major factor in reducing the rate of lifetime psychological injuries suffered by veterans of that war.[15] Combat stress, shell shock, battle fatigue, and now PTSD have stricken soldiers since the dawn of war. No soldiers are immune from the stresses of combat; all warriors are in some way affected by combat. We will continue to send men and women into combat, so we should do our best to care for them. For starters, we must acknowledge psychological injuries.

No doubt there have been soldiers who, for one reason or another, broke down in every campaign.[16] As early as 1916, military psychiatrists believed if victims were

treated quickly and expertly, shell-shocked soldiers would recover sufficiently to return to the war as effective soldiers. Or they could resume normal civilian life and not be a burden to the state in years to come.[17] Although armies endured centuries of experiences of psychological effects of war, the medical community has only recently acknowledged the psychological effects of combat. In 1980, following the Vietnam War, the American Psychiatric Association formally defined PTSD, categorizing it as one of the anxiety disorders.[18] By December 2006, one in four soldiers discharged after serving in Operations Enduring Freedom (OEF) and/or Operations Iraqi Freedom (OIF) had filed disability claims, and more than 40,000 have been diagnosed with PTSD.[19] Would early treatment of these victims have significantly reduced this number of PTSD cases? Of course, we do not know how many – if any – of these victims sought early treatment – or how many experience a late onset of PTSD.

Early intervention could likely pay dividends in better outcomes well into the next generation. For practical and humane reasons, we should afford our service members the opportunity to seek and receive treatment. Researchers from Walter Reed Army Medical Center suggest that over 95% of soldiers who receive forward mental health support are returned to duty.[20] But those treated in rear areas are susceptible to evacuation syndrome, which is the paradox of combat psychiatry.[21] Psychiatric casualties must be treated, but if soldiers begin to realize that psychiatric casualties are being evacuated, the number of psychiatric casualties will increase dramatically.[22] When the name “shell-shock” was coined, the number of men leaving the trenches with no bodily wounds leapt up.[23]

In contrast to evacuation, soldiers treated immediately near their units have a higher probability of returning to their comrades in arms.[24] Early treatment on the battlefield for PTSD would likely pay huge dividends in sustaining the deployed combat force, in reducing disability claims, and in de-stigmatizing a mental health issue related to wartime service.

Messages Do Matter

Messages do matter, but some messages are slow to resonate. Faced with a horde of service members coming back from combat in anguish, the Pentagon has made the diagnosis and treatment of post-traumatic stress disorders a top priority.[25] Secretary of Defense Robert Gates states:

> The examples provided by these brave warriors reinforce the message that there is no weakness in asking for help. On the contrary, it takes tremendous courage and strength – and gives troops the skills to identify and deal with future symptoms from a position of confidence and strength. Completely removing the stigma may very well be the work of generations, but we will continue to do everything possible to chip away at it.[26]

Most recently, the Army has transformed the way it utilizes its behavioral health assets. However, these newly established policies and procedures will require time to reach the lowest level for proper implementation. For that reason alone, the Army needs to get the message that seeking help is not a sign of weakness. This message should resonate at all levels of leadership.

However, historical images and past stigmas associated with mental health are not easily overcome. Stigmas have their own dark past. Currently, they can still influence attitudes, regrettably usually negatively. However, humiliation and degradation usually reduce military effectiveness.[27]

Both Guard and active soldiers are reluctant to take advantage of mental health services. A 2004 study of soldiers and Marines returning from Iraq and Afghanistan stated that only 23 to 40 percent of those with PTSD actually sought medical care.[28] This same study indicate there was a significant risk of mental health problems and that the soldiers reported important barriers to receiving mental health services, particularly the perception of stigma among those most in need of such care.[29] The primary reason for not seeking care was that the soldier believed the leadership would treat them differently, see them as weak and consequently having less confidence in them. [30] Many service members feel that seeking mental health care could damage their careers, jeopardize their security clearances, and diminish the trust of other service members.[31] Soldiers simply do not want to jeopardize their reputation among their peers and leaders for fear of being seen as weak. The warrior's ethos has no place for the weak. But seeking help should not be regarded as weakness. But it is.

Problem of PTSD in the National Guard

Guard soldiers have less training and preparation for deployment and less reintegration support. They disperse rapidly after deployment. These factors put them at significantly higher risk for stress-related disorders than active-duty soldiers.[32] Citizen-soldiers are particularly vulnerable due to demands back home; their careers and businesses have been put on hold; their families have little service-provided support. Their transition from war zone and home again is more stressful. [33]A 2004 analysis of Operation Iraqi Freedom veterans who received Veterans Affairs (VA) healthcare revealed that 58% of the veterans seeking treatment were members of the National Guard/Army Reserve. Likewise, 71% of Operation Enduring Freedom veterans who utilized VA services were citizen-soldiers.[34]

The current operational tempo, surges, and multiple deployments may bring success to both current operations. But this success will come with a risk for the future force. DOD and the National Guard do not have the option of turning down missions, regardless of risks to the nation's security. But Guard leaders do have a moral obligation to Guard soldiers sent to war. Most Guard soldiers' transition back to civilian status from combat without mental health problems; most are able to readjust successfully. Many return with renewed confidence in their abilities to overcome hardships. Wartime trauma can induce us to cherish our mortality, to savor and embrace it.[35] It inclines us to treasure the precious relationships we have with those we love.

But trauma can work both ways. A recent Rand study found Guard soldiers to be at significantly higher risk for mental health problems than those currently on active duty.[36] Therefore Guard leaders must do all they can to strengthen the care of those who have been psychologically injured. To retain the force, we must care for the welfare of our traditional citizen- soldiers and their families.

Guard soldiers who are reintegrating directly back into civilian life with PTSD or with a late onset of PTSD often affect the entire circle of family, friends, employers, and community.[37] Their personal and emotional issues take a toll on their military careers; these issues also impair relationships, disrupt marriages, aggravate difficulties in parenting, and cause problems in children that may extend the costs of combat experiences across generations.[38]

PTSD is hard to diagnose and more difficult to treat. In fact, most cases go untreated and will seriously impact lives of our soldiers for years to come.[39]

Consequences of mental health conditions may grow more severe, especially if left untreated.[40] Victims may exhibit higher rates of unhealthy behaviors. For example, they are more likely to have other psychiatric problems, such as substance abuse and suicidal tendencies.[41]

When OEF/OIF deployments started, the military had little recent experience with reintegrating Guard combat veterans back into their communities.[42] It was not uncommon for returning Guard soldiers to get off the plane from combat and receive the entire reintegration briefing on the tarmac. Guard soldiers were then sent home, where they were expected to get on with their normal lives.[43] Following the initial mass deployments of Guard soldiers, the Army was unprepared to give these citizen-soldiers the same care it was giving to returning active-component troops.[44] A recent study by Rand revealed that even though reserve component soldiers are more likely than active duty soldiers to report mental health problems, they were also less likely to be referred for treatment.[45]

Problems Associated With Rapid Out Processing of Guard Soldiers

Each soldier walks away from combat carrying something. Numerous soldiers carry a new found confidence, while others carry traumatic experiences that drastically impair their readjustment. After serving some of their longest tours, Guard soldiers undergo the quickest out-processing. When Guard soldiers are released, they scatter across the state with little or no access to support and services.[46] They usually do not report for their first post-deployment individual training drill (IDT) for three months or more. On the other hand, our active component soldiers are required to report for two weeks after redeployment for reintegration training before signing out on initial leave. The Guard's goal was to get their citizen-soldiers back as quickly as possible to their

employers and families. Although laden with good intentions, this rush could in fact delay the opportunity to provide an additional preventive measure for diagnosis of PTSD. The rapid rush to out-process Guard soldiers simply deprives them of the care provided by the active component in the manner in which their mental health screening is conducted and the lack of decompression time.

Guard leaders always have the ultimate responsibility to choose the hard right over the easy wrong. If a mandatory time is set aside for the out-processing window, it eliminates peer or leaders' pressure to hurry up and "get-err-done," when it comes to best serving the individual soldier, in particular the mental health assessment. Desperate to get home, Guard soldiers will say anything to hasten their return home to loved ones, especially their young children.[47] Results of health assessments done during and immediately after deployments differ from assessments done months later, where 42 percent of reserve component soldiers were more likely to report mental health problems.[48] As previously stated, PTSD is best dealt with early. If it is not diagnosed in theater, the next best opportunity is a thorough mental health screening at the de-mobilization site. This screening would identify returning Guard soldiers who are struggling to deal with the stresses of deployment and war prior to being released from active duty.

Up through the Korean War, the slowness of travel ensured a gradual re-entry for soldiers returning from combat. Instead of being abruptly thrown back into society without a chance to decompress and process their wartime experiences in a safe, quarantined environment, they took slow boats home and endured lengthy out-processing.[49] Nowhere is the need more apparent for gradual re-entry than within the

National Guard. Guard soldiers could benefit from the gradual transition from the turmoil of a conflict zone to the peace and tranquility of home. But the typical 72 to 96 hours of their re-entry offers too little time for decompression.[50] If rushed through the de-mobilization, Guard soldiers have no chance to "debrief," to talk about what had happened with trusted people who understand and share their experiences. Extra decompression time does not prevent stress-related injuries. But it does give soldiers more time to evaluate their situation, and it facilitates the reintegration with families and friends back home.[51] According to Dr Jonathan Shay, author and longtime VA psychiatrist, "Men and women returning from combat should debrief as units, not as isolated individuals". [52] Unit rotation is the second best preventive measure for reducing PTSD.[53]

Guard soldiers do not have the luxury of simply going back to post and hearing again messages they missed during their out-processing briefs. During de-mobilization, they have only one opportunity to comprehend and retain such messages. Increasing the time-line over which key medical information can be retained could reduce PTSD issues. Many counseling services available for the Guard – like Military One Source, My HealtheVet, and the VA National Center for PTSD – are web-based and can be accessed, if needed, after the soldiers return home. But soldiers must be aware of these sites, and they must be able to access them.

One way to increase the care for Guard soldiers suffering from PTSD would be to ensure Guard soldiers are properly entered into the VA database prior to departing from active duty. Additional de-mobilization time could easily eliminate the struggle and frustration experienced by many Guard soldiers who need medical services, but who

must deal with unnecessarily complex paperwork prior to receiving care and counseling. Before Guard soldiers can receive VA services, they have to prove they were on active duty, prove they were in combat, and prove they were injured. Valuable treatment time is wasted when veterans have to prove they qualify for medical care.

Yellow Ribbon Reintegration Program (YRRP)

The Yellow Ribbon Reintegration Program (YRRP) was created to bridge the gap between the active components' access to reintegration services following lengthy deployments and the National Guards' lack of access to such services. Collaboration between Congress and DOD led to the YRRP, a national combat veteran reintegration program that provides Guard soldiers and their families with information, services, referral and proactive outreach opportunities throughout the deployment cycle. The YRRP takes family readiness to the next level by providing outreach services for such matters as marriage counseling, services for children, suicide prevention, substance abuse and treatment, and mental health awareness and treatment.[54] The YRRP is designed to take care of soldiers and their family; to make them self-reliant and more resilient.[55]

Although active component soldiers have ready access to counseling and care, Guard soldiers tormented with PTSD have no such access. [56] Accordingly, the YRRP was designed to facilitate Guard soldiers' reintegration in two weekend training sessions during the initial 90-days break period. The YRRP is primarily devoted to helping Guard soldiers and their family members address readjustment issues and to better recognize behaviors associated with PTSD. During each session, Guard soldiers are thoroughly briefed on services and support channels that are available for Guard soldiers and their families. During these sessions, Guard soldiers spend time talking about reintegration

issues with fellow Guard soldiers and their leaders. During both weekends, the state Chaplain conducts sensing sessions with Guard soldiers and their family members, focusing on relationship and health issues. These presentations are designed around questions and answers regarding what is considered normal readjustment behaviors and what should be considered as potentially harmful behavioral traits.

The VA staff provided "boots on the ground" for Yellow Ribbon events initiated in 2009 for each of the services during the 45 to 90-days post-deployment cycle.[57] VA has supported over 665 of these events nationwide, reaching over 80,000 service members and 54,000 family members.[58] But VA is only on hand to help with enrollments and to inform Guard members returning from combat about available benefits.[59] The YRRP should incorporate counselors in the mix and arrange for the VA or Vet Center to provide critical screening to identify soldiers struggling with symptoms associated with PTSD. Referrals received during the YRRP would greatly enhance rapid treatment and care for returning soldiers and their families.

Guard Soldiers' Access to Health Care

If the nation is to honor its commitment to make available care and support for service- related injuries and disabilities, it must acknowledge the problems many Guard soldiers face in getting proper health care. When Guard soldiers return home, they are returned not to an active duty base with nearby hospitals and medical care, but to home communities that often lack medical services capable of careful follow-on diagnosis and treatment of war-related maladies.[60] Lack of entitlements for Guard soldiers limits their access to many services readily available to the active force. Guard soldiers are additionally confronted with logistical barriers to mental health treatment, such as time, money, and eligibility.[61] Geographical dispersion of Guard soldiers limits access as well.

Active duty soldiers who are injured in combat receive medical care through their employer, DOD. National Guard soldiers report back to their civilian employers, who cannot be expected to pay the bill, or even to pay for leave time for citizen-soldiers who need time off to treat or recover from service-related injuries. Active duty soldiers would never be expected to lose a day of pay or have to pay for travel to seek treatment. Active duty personnel have TRICARE coverage to treat mental health, whereas Guard soldiers now have TRICARE benefits extended from the original 90 days to 180 days after they have served under Title 10 deployment orders. Symptoms of PTSD and major depression can have a delayed onset, appearing months after exposure to the causative stresses.[62]

OEF/OIF veterans are eligible to receive care through Veterans Health Administration for five years following military discharge.[63] The DOD does not offer a unified mental health program for both active and reserve components. The vast majority of DOD services are available only for active duty soldiers, leaving the Guard soldiers after multiple deployments to seek out their only option, VA.

Recommendations for Senior Guard Leadership to Consider

National Guard leaders must acknowledge the invisible wounds of war and take responsibility for the care of their own. Solutions should provide Guard soldiers many of the same programs offered to active component soldiers in the transition from combat to civilian life. Potential solutions should accord with Army Vice Chief of Staff General Chiarelli's advice "to give the Guard soldiers the same care offered to active components soldiers." So the first two recommendations seek to provide Guard veterans with similar measures that enable active duty soldiers to reintegrate. The final two recommendations are Guard-specific preventive measures to enable trained

personnel to provide unprecedented levels of support and care in order help diagnose or assist in follow-on treatment of PTSD.

Both active duty and Guard leaders need to target the large number of troubled soldiers who refuse to seek help for their mental problems.[64] The message does matter: It can eventually overcome the stigmas associated with mental health problems; it can persuade those who need it to seek the benefits of early treatment. COL. Richard B. O'Connor, former Iraq Veteran and author has this to say about the leader's role:

> Unit leaders must embrace soldiers who are suffering from combat stress and thereby remove the stigma and barriers to seeking professional mental health care. Senior leaders in our armed forces have claimed that until battalion commanders and command sergeants major accept the fact that psychiatric casualties are an inevitable consequence of combat and take the initiative to incorporate the importance of addressing combat trauma and stress in the training program, the Army will not dispel the current organizational barriers that inhibit soldiers from seeking mental health treatment.[65]

Recent cooperation between DOD and Veterans Affairs has further integrated the VA into the YRRP redeployment events. Support from Guard leaders and family readiness groups across the nation can make a difference by explaining the problem and providing the knowledge needed by deploying soldiers, who need survival skills through their deployments and effective reintegration programs for both soldiers and their families upon return. Support systems may serve as buffers. Social support may help veterans find meaning in their experiences and sacrifices; this kind of empathetic support has been shown to lower risk for subsequent PTSD.[66] Clearly, Guard soldiers who have considerable social, financial, and educational support fare better: Polices that provide such resources could be as effective.[67]

Sustain the Force through Demobilization Time that Matches that of the Active Component

Historically, troops that come home quickly have had more problems than those who were given time in re-acclimate.[68] Research affirms that soldiers who have been united immediately with their families are more likely to have problems in reintegrating than those who have had decompression time prior to reuniting with their families.[69]

W should increase the Guard reintegration program from three days to ten days to match that of the active component. The Chairmen of Joint Chiefs of Staff vision for 2010 calls for sustaining the force. Can a mere seven days make that much of a difference for the Guard? Might a deliberate effort to ease Guard soldiers back into home life actually strengthen the force? Would extending the time afford Guard commanders a greater opportunity for early intervention by providing time for adequate mental health assessments (not just a checklist) with mental health providers? At a minimum, providing additional time would enable Guard soldiers to complete a verifiable VA database application. This additional time would also give Guard soldiers time to share war experiences and possibly acknowledge combat stressors with other soldiers who have had similar experiences. “The long trip home” is generally viewed as an opportunity for mutual support and communal reworking of combat trauma.[70]

As previously stated, soldiers, regardless of their ailments, are more motivated to get home than to share their concerns over their own welfare. Research shows that veterans who identify and address their problems related to their war experiences as soon as possible are more than likely to overcome them.[71] Soldiers may not even know they are suffering from PTSD, which only increases the Guard’s need for adequate

mental health assessments and evaluations prior to returning these soldiers to civilian status.

Resiliency training

A good leader can reduce the negative impact of exposure to a traumatic event, but cannot completely eliminate it.[72] Good leadership, training, and unit cohesion appear to be predictors of resistance to PTSD following combat.[73] Excellent training engages the whole person: mind, body, emotions, character, and spirit. [74] It also prepares soldiers for the demands and stresses of war and other situations with mortal stakes.[75] Sustained resilience training should be implemented during pre-deployment, deployment, and post-deployment phases (deployment cycle training), to build soldiers' inner strength by enabling them to face adversity, fear, and hardship with courage and confidence.[76] Resilience training, comparatively speaking, is a combat strength multiplier.

The Army's new Comprehensive Soldier Fitness (CSF) program was designed as a holistic approach to fitness to enhance performance and build resilience in the force in this era of persistent conflict and high operational tempo.[77] As of December 2009, more than 150 Soldiers had attending the second iteration of the 10-day "Train-the- Trainer" Master Resilience Trainer (MRT) course. Although only five slots in this course were allocated to the entire National Guard, approximately 20% of Guard soldiers are currently mobilized. Consequently, this program is currently preparing one Master Resilience Fitness Trainer for 14,370 Guard troops. The CSF is designed to instruct soldiers at each leadership development level. Most Guard leadership courses are only two weeks long, other than Basic Training and Basic Officer Leadership Course (BOLC). However, it seems reasonable to give equitable slots to active and reserve

components during the current operational cycle, since the total force includes large numbers of deployed Guard soldiers.

In order to compensate for the lack of MRT slots, The Kansas Army National Guard has designed its own Holistic Fitness Program (HFP) to train-the-trainer in a two-day window. The two-day time frame fits the Guard's IDT schedule, so the HFP is being incorporated into leadership and professional development courses conducted by the National Guard.

Just as we prepare soldiers to survive combat using individual tactical and technical skill sets, all Guard soldiers should receive resiliency training. Veterans' reactions to war's traumatic incidents have always varied. Training soldiers to handle stress after a traumatic event is essential, because trained soldiers learn how to cope with post-traumatic stress before it becomes a disorder. Furthermore, resiliency training across the board would likely facilitate de-stigmatizing the need for mental health assistance.

Deployed Guard Unit Implement Soldier Outreach Program

Another recommendation is for each deployed Guard unit to implement a soldier outreach program that enables returning Guard soldiers to better readjust to civilian life. Units deploying in company size elements are authorized to assign one of their personnel to the rear detachment during the deployment. This individual is responsible for the Guard's support network for soldiers and their families. This recommendation would increase that individual's orders by 90-days beyond the date of the deployed unit's return home. The sole mission for this individual soldier would be to make face to face contact with each redeploying soldier at their home of record (HOR). This extra

preventive measure would take soldier care to the next level by enabling Guard soldiers to more effectively reintegrate back into the civilian world.

This outreach program requires the rear detachment soldier to physically travel to soldiers' homes of record and assess the condition of the soldier and that of the soldier's family or supporter. This same rear detachment soldier would remain in constant touch with family members during the deployment and establish a bond with family members.

Conceptually, this simple 90-day extension has tremendous potential benefits to assist Guard soldiers' transitions. A sergeant who was awarded 50% percent disability pay over a 30-year period would currently receive 464,940 dollars, but 90-day extended orders for one sergeant would average 7,751dollars. Costs associated with medical expenses and consequences of only one case of PTSD would clearly outweigh the costs of extension of orders for this one soldier. This rear detachment soldier, properly trained in behavioral health, would be afforded the time and opportunity to talk with each redeploying soldier and the family in the comfort of their HOR. The rear detachment soldier could then persuade troubled soldiers to seek help and thus facilitate early detection of PTSD. The two key elements required in helping soldiers with PTSD integrate back into their families and communities are proper diagnosis and treatment. Theoretically, one rear detachment soldier per each deployed Guard unit contributes another layer of opportunity to help Guard soldiers mitigate their PTSD issues.

The Healing Power of a Soldier's Story

Telling your story is a way that putting your story in the context of the large flow of events. The story reveals patterns and meaning that storytellers might otherwise miss

as they go about the mundane activities of living. Storytelling might show warriors the way home.[78] Storytelling can open the door for understanding and even enlightenment.

Vet Centers are based on the concept of "Vets-helping-Vets" mainly because veterans feel more comfortable with other veterans who understand what they have been through. The use of groups to treat PTSD was pioneered with Vietnam War veterans.[79] Guard soldiers have a golden opportunity to participate in a group session with family members present during the Yellow Ribbon Reintegration Program. However, we should consider taking this one step further: When soldiers start drilling following deployments during their scheduled individual drill training (IDT) weekends, they do not need to hone their fighting and tactical skills at that point. Rather, this is an excellent opportunity for incorporating mental resiliency into the training schedule for redeployed soldiers.

This Guard group session should be led by trained counselors. However, compulsive-war storytelling may become a means for veterans to hide from their feelings, rather than accessing them.[80] A survivor might endlessly repeat the details of an event but not experience the release of related emotions. [81] Healing storytelling, on the other hand, provides meaning and yields relief from PTSD stressors.[82] PTSD and the story of what caused it always concern more than only the survivor.[83] Until it is properly addressed, it reverberates through the survivors' relationships and down generations, harming everyone it touches.[84]

If we fail to add this reintegration time in our drill schedules, we fail to recognize the worth of the healing power of soldiers telling their stories. Therefore, it is recommended that we allow time during IDT weekends every month, up to the first six

months of post-deployment, for soldiers to have sensing sessions with a counselor. This affords soldiers the opportunity to share their stories with deployed unit members, who may offer helpful views of each soldier's translation of events and offer coping strategies. This Guard group session may reveal that fellow Guard soldiers are having similar difficulties readjusting to their peacetime environments. Including counselors in these sessions would benefit the soldiers by differentiating between normal symptoms and the healthy growth process from distressing symptoms that may develop into PTSD.

TRICARE West Healthcare has provided funding to station counselors with several Army and Air National Guard units during their drill weekends.[85] These counselors are available to talk with personnel and observe Guard soldiers and airmen in a comfortable, less formal setting. The success of this program should reinforce the recommendation for DOD and the National Guard to strive to have every TRICARE region embed counselors into armories for several months following redeployment. Recognizing and implementing these recommendations will enable all Guard leaders to embrace the importance of soldiers learning to live with their story, witnessing others soldiers' quest for help, and sharing coping skills. These endeavors conducted during an IDT time would go a long way to sustain the force, dispel current organizational barriers, and remove stigmas at the lowest unit level.

Conclusions

For every life a soldier saves on the battlefield, this soldier could return home with PTSD and affect the lives of several immediate family members.[86] Invisible wounds of wars require special attention and a high priority. Commanders still have the

responsibility for getting their Guard soldiers out of combat both physically and mentally. 1LT Lee Alley former Vietnam Veteran eloquently states:

> We should rotate troops in war zones, not as individuals, but as units. When they return home we should shower them with gratitude and give those who need it counseling and ID early any symptoms of PTSD.[87]

It is incumbent upon the National Guard to ensure that future Guard soldiers have adequate prevention and treatment programs. Economically, prevention is less costly than struggling to find a cure. Our nation depends upon its citizen-soldiers to be ready to respond in order to protect our freedoms during times of national emergencies. Citizen-soldiers need to remain resilient, healthy, and productive members of their communities.

However, In order to really change things, we must be ready to listen to what our veterans have to say. More importantly, we must accept the realities of war and respond positively to undeniable evidence that a large portion of Guard soldiers are returning with PTSD. But even with vigilance and with all the right supports in place, the invisible scars of war can haunt a warrior for a lifetime.[88]

It is essential that Guard leaders remain responsible for recruitment, preparation, and sustainment of its citizen-soldiers. This responsibility includes proper care of our injured warriors. By extending the de-mobilization time frame and incorporating some of the same preventive active component institutional procedures, Guard soldiers would have a better chance for a healthy return to their previous civilian lifestyle. Providing Guard veterans with extra face time with trained personnel would increase the probability of properly diagnosing mental health problems and effectively treating severe mental trauma.

Congress and the Pentagon have markedly improved sustainment of the force and care for the wounded, to include psychological injuries. But many worthwhile programs either quickly expire or are not available to Guard soldiers. After nine years of war, our Guard citizen-soldiers have justified themselves by carrying much of the load of two major operations. Why should they have to justify their entitlements to mental health care after volunteering to serve their country in a time of war? Guard soldiers should be afforded every opportunity to reintegrate successfully back into society and to walk proudly down Main Street, USA.

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